

MICARE REGISTRATION FORM

MICARE FACTS AND REGISTRATION

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), this notice informs you of the purpose of this authorization and how it will be used. Please read it carefully.

PRINCIPAL PURPOSE(S): *This authorization allows the Military Health System to release an individual's protected health information to RelayHealth.*

AUTHORITY: *Public Law 104-191 104-191; E.O. 9397 (SSN), as amended; DoD 6025.18-R.*

ROUTINE USE(S): *Upon authorization from the individual, protected health information may be released to the individual for personal use, or to the individual or a third party for insurance, continued medical care, school, legal retirement/separation, or other reasons.*

DISCLOSURE: *Voluntary. This form will be destroyed upon registration completion.*

What is MiCare?

MiCare is a confidential online healthcare messaging system that allows you to communicate with your healthcare team, get test results, request prescription refills and maintain your own personal health record. In the future, information from your electronic health record will be available to transfer directly into your personal health record.

Who can use MiCare?

Any Tricare Prime empaneled patient. Once registered, you will remain in the system. When PCS-ing, your account will travel with you so you are able to connect with your new clinic.

Is my privacy protected?

A secure connection is established with the browser to validate that your personal information is encrypted and coded for transmission and storage. This ensures that your information and messages are only accessible by you and your healthcare team. In addition, MiCare is in compliance with the Health Information Portability and Accountability Act of 1996.

How do I register?

Fill out the registration form below and return it to your Medical Treatment Facility (MTF). An MTF staff member will verify your identity. Following the in-person submission of your registration, you will receive an email asking you to complete the registration process online.

MiCare Registration Form

First Name: _____ Last Name: _____

Date of Birth (MM/DD/YYYY): _____ Home Zip Code: _____

Your SSN/DoD ID Number: _____ Gender (circle one): Male Female

E-Mail Address: _____

Provider/Primary Care Manager: _____

CLINIC USE ONLY

Patient ID Verified: **Date:** _____ **Staff Initials:** _____

E-mail Invitation Sent: **Date:** _____ **Staff Initials:** _____